TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HCAA Medical Group PA

Respondent Name
Granite State Insurance Co

MFDR Tracking Number
M4-15-3059-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient has numerous claims that remain unpaid or denied."

Amount in Dispute: $99.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is maintaining their position that the 10/9/14 date of service w/HCAA Medical Group, PA was paid ($383.89) in accordance with State Fee Guidelines."

Response Submitted by: AIG, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2014	97001	$99.79	$99.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. No explanation of benefits was provided by either party in this dispute. The Division will proceed with its adjudication from the information timely submitted by both parties.

Issues

1. Did the respondent support that payment was made?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "The Carrier is maintaining their position that the 10/9/14 date of service w/HCAA Medical Group, PA was paid ($383.89) in accordance with State Fee Guidelines. No documentation was found to support the claim of payment. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)."
    - Procedure code 97001, service date October 9, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.2 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.2. The practice expense (PE) RVU of 0.87 multiplied by the PE GPCI of 0.916 is 0.79692. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.816 is 0.0408. The sum of 2.03772 is multiplied by the Division conversion factor of $55.75 for a MAR of $113.60. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $113.60. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $99.81.
3. The total allowable reimbursement for the services in dispute is $99.81. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $99.79. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $99.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $99.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.